Alabama Medicaid ITB for Medical Quality Services
Final-Bid Questions Received through January 17, 2007
Bid #07-X-2176768
January 19, 2007

1. Please clarify inaccessibility to Chapter 44 in the Administrative Code as referenced in Chapter 7. In attempting to access the Chapter 44, a message is returned which states "Reserved".

   Response: Chapter 7, page 12, contains a reference to Chapter 44. Chapter 44 previously contained inpatient hospital admission criteria and was repealed in 2004. Current criteria for hospital admissions are found in Chapter 37. Hospital admission reviews are not a component of this ITB.

2. Please clarify which medical services are included in the PA process.

   Response: Please refer to attachment O and C. Attachment C lists codes which currently require PA for payment by Medicaid. There are some codes, such as unlisted procedures or cosmetic procedures which would rarely, if ever, be requested for authorization. Attachment O provides a list of service types and the volume of services authorized. The provider identifies the service type on the PA request form in addition to the CPT/HCPC codes for service.

3. Please provide clarification of PA's for hospital inpatient care as listed on Attachment O.

   Response: Inpatient prior authorizations are for extended maternity care days and inpatient psychiatric days.

4. Why did you decide to out-base these functions at this time?

   Response: During the development of PA criteria, it became evident that there might be a more efficient mechanism for handling these processes. The Agency decided to proceed with the procurement of outside expertise.

5. Would you please provide medical claims data for the last two years in a standard format?

   Response: The intent of this ITB is to review PA's for medical appropriateness and medical record documentation for medical appropriateness. The history of volume of such reviews is contained within attachments D, E, and Z. The State will not provide medical claims data at this time due to time constraints associated with implementation of the new AMMIS system.

6. Would you please clarify which dental services require prior authorization?

   Response: Dental services are not included as a function of this ITB. Please refer to attachment O. It is not listed as a service type.

7. The table which is attached to the response does not contain a title, please clarify.

   Response: The table was included as a response to bidder's questions under attachment B. The question states, "Can the State provide the breakdown of the number of children vs. adults that compile the average number of Medicaid eligible for 2004-2005?"

8. Medicare beneficiaries do not specifically mirror Medicaid benefits. Could you be specific about what is not covered by Medicaid?

   Response: There are some situations where traditional cosmetic services may be medically necessary and covered by the State. The intent of the State is not to cover cosmetic procedures but to provide a mechanism for approval for medically necessary procedures as determined by criteria developed.

9. On page 15, Item 5 of the initial pre-bid questions and responses, the State asks for clarification of turn over rate. The intent was denials that are overturned and become approved in the reconsideration process.

   Response: There is no historical data recorded regarding the number of requests for reconsiderations that become overturned in the reconsideration process. For the purposes of this ITB, reconsiderations are considered a new PA request and are included in the totals in Attachment O.

10. Will the questions being submitted at the Pre-Bid Conference become a formal part of the deadline for written bidder's questions of January 17, 2007?

    Response: Yes. As a disclaimer, any verbal responses during the Pre-Bid Conference will be written and posted to the website by January 19, 2007 and these will be the official State responses.

11. Are quality screenings to be used during the retrospective or prior approval process?

    Response: We have not envisioned this to be a part of the Contract at this point. We have indicated that the Contractor should make recommendations to policies and procedures for areas of improvement but this is not a specific component of this bid.

12. I have a whole page of questions. Do you prefer that I ask them now or submit them in writing?

    Response: This is our only opportunity for dialogue. Either method is acceptable.

13. Section 3.1 Medical Criteria Development (page 8). This section of the Scope of Work indicates the Contractor shall, at a minimum, "revise, develop and complete policy" for specific services. This section also notes that "other services shall be identified during the Contract Implementation Phase for which the Contractor shall develop medical review policy criteria."

    The PA policy material (Table of Content; updated December 08, 2006) provided at the mandatory ITB pre-bid conference indicates a number of policies that have not been finalized, including policies that are not listed in Section 3.1 Is the Contractor expected to develop or complete review criteria for these services in addition to those listed in Section 3.1?

    Response: The State has a committee which is actively working on criteria development. Section 3.1 indicates that the Contractor would at a minimum complete or develop criteria for those listed. Most of the policies listed in the Table of Contents are in some phase of development and Contractor may be asked for assistance in finalizing these in addition to those listed in Section 3.1.

    Additionally, are such services currently required by Alabama Medicaid? If so, what Medicaid review criteria are currently being used? If not, what volume of review activity does the State anticipate for these services?

    Response: With the exception of external pressure wound therapy, these are covered Alabama services. If there are no developed criteria, the review function requires the expertise of the physician. The State has built in time during implementation March 1 through July 1 for the Contractor to complete this requirement.

14. Section 3.2 Hospice Admission Reviews, 3.3 Institutional Admission Reviews and 3.4 PA Reviews. These sections of the Scope of Work all indicated that the Contractor will receive medical records directly from the provider. These sections of Scope of Work, amplified to responses to bidder questions, indicate that the Contractor will use AMMIS as an integral part of review process.

    Under the current review process, medical records are submitted to EDS and the fiscal agent scans documents into AMMIS. Please verify that under the new contract, the Contractor, not the fiscal agent, will be responsible for scanning records into AMMIS.

    Response: Hospice and institutional applications are not scanned but are hard copies that are filed and stored. PA requests that are mailed to the Fiscal Agent

(EDS) are either scanned into the system or forwarded to the State dependent upon the documentation requirements. We have not envisioned this function as an integral part of work performed by the Contractor.

15. Section 3.5 Quality and Outcome Review: Why were these specific counties chosen for quality and outcome reviews for residents with heart disease and/or diabetes?

    Response: The State is engaged in an evaluation of the area of the State known as the Black Belt. This effort has broad support and involvement, including that of the Governor. Health is one issue of concern in this region. Because there are ongoing efforts in this region through our state coalition, we saw this as an opportunity to build in another resource. Therefore, these counties were targeted for the first year.

16. Section 3.5 Quality and Outcome Review: Will you be looking at individual assessments case by case or just a summary?

    Response: We are looking for a summary. We do not anticipate reviews that are specific at the individual patient level, but desire information that can be used to assist and direct the development of interventions that will address medical needs in the area studied. At this point, we are looking at this being a diagnosis management tool for these individuals.

17. Section 3.5 Quality and Outcome Reviews: For the purpose of costing, please clarify what data will be provided to the Contractor to comply with this requirement. Are individual lab and pharmacy data linked to the claims data so that the lab and pharmacy data can be included in the analysis under this requirement?

    Response: Yes, the Contractor will have access to all the pertinent claims data. This includes lab and pharmacy.

18. Section 3.6 Additional Contractor Responsibilities: Please clarify work related to training around the State.

    Response: We envision that the Contractor may be requested to attend provider organizational meetings to foster good provider relations and to address issues specific to the provider organization. The State would not typically anticipate any such training. A maximum of three such trainings could be required.

19. Section 3.6 Additional Contractor Responsibilities: Would you elaborate on the State's intent for the Contractor to identify and monitor cost shifting? Is this individual cost shifting or by analyses?

Response: This is an area where we anticipate the Contractor would identify areas of improvement or how the State can improve performance. This is not intended to be patient specific. We do not anticipate any area where the contractor would work on or with an individual patient.

20. Section 3.11 Key Personnel (page 18). This section of the Scope of Work indicates the Clinical Director position must be a Full Time Equivalent (FTE). No similar requirement is stated in this section for the Project Manager or Consulting Physician. This section also specifically states that Consulting Physical Therapist "should not constitute one (1) FTE." Is it correct that the Clinical Director is the only key staff position required to be assigned full-time to the contract? Is it permissible to assign a full FTE to other key positions, including Consultant Physical Therapist(s)?

    Response: It is correct that the Clinical Director must be a full time position. While it is permissible to assign a full FTE to other key positions, including Consulting Physical Therapist, it is not required. The State does not intend to prohibit use of FTE's in any position if the bidding vendor feels that level of staffing will lead to the most effective, efficient operation.

21. Because your response indicated the Contractor would have to access and use the EDS system opposed to the Contractor utilizing their own system, will the EDS system accept multiple service lines?

    Response: Yes. The new AMMIS system to be implemented in May will accept multiple service lines.

22. If a PA contains a reduction in service is this just approved or denied or is there an opportunity for an appeal?

    Response: Yes, the process can be appealed. For example, if a private duty nursing case is reduced from 24 hours per day to 18 hours per day the decision can be appealed. When a partial approval is given for a PA, the reviewer must indicate in the external text which procedure code or codes were not approved, additional documentation that is required for approval and the time frame of 30 days for reconsideration. For PDN, this procedure is required in addition to a letter to recipient and or guardian including their right to a Fair Hearing.

23. Does EDS issue PA numbers or will this be a Contractor responsibility?

    Response: EDS automatically assigns all PA numbers.

24. Attachment I: What is the timelines requirement for EDS to submit requests to the PA unit?

Response: EDS must scan and submit requests to the PA unit within 48 hours of the receipt of the request. The Contractor clock will start with the date of availability electronically or date stamp received.

25. Attachment D: Please define PA conditional approval.

    Response: This is a condition in which the review of the PA is determined to meet medical criteria and medical necessity and the approval is contingent upon additional supporting documentation such as documentation of equipment delivery.

26. In reference to question 21 above, is the conditional approval primarily for equipment?

    Response: Yes.

27. Attachment 49, Long Term Care Admissions/Records, Hospice Requests, there appears to be incomplete boxes.

    Response: The revised document will be attached which includes the complete text.

28. 3.2 Hospice Admission Reviews: This section indicates applications not acceptable will be returned to the Provider. How much time does the Provider have to respond to such requests?

    Response: The provider has ten working days from date of receipt in which to respond to such requests.

29. What happens to the Contractor's clock when information is returned to the Provider for additional information?

    Response: The clock resets.

30. Please clarify if ICF/MR facilities are sampled the same as nursing homes.

    Response: The sampling is the same. The levels of care criteria are different.

31. Is there any situation where a Nurse can deny a case or does it always have to be done by a physician?

    Response: In reference to the PA process, if there are defined criteria a non-physician position may approve or deny. Medical level of care reviews for hospice and institutional programs that do not meet criteria are referred to M.D. for final determinations. These referrals to the M.D. are only after attempts have been made to obtain additional documentation from the Provider.

32. Please clarify the references in Attachment O regarding home health care and home health visits.

    Response: The State has benefit limits for home health. Children under the age of 21 may have additional home health visits. Any additional visits approved are reflected under Home Health visits. Additional visits by other disciplines may also be prior approved. These are captured under Home Health Care.

33. Attachment C, Page 40: Procedure Codes Requiring Prior Authorization. Please verify whether these post-HIPAA implementation codes require prior authorization:
    - W9200
    - X2091
    - X2780
    - X6200

    Response: These codes are no longer used by Medicaid.

34. Please clarify whether the Contractor will prior authorize all requests for ground transportation. Is it permissible to assign non-clinical personnel to conduct these reviews?

    Response: Non emergency ground ambulance transportation requests will be processed by the Contractor. Non-clinical personnel may conduct these reviews.

35. Should the review volumes increase, will there be an opportunity for Contractor to adjust its pricing? If so, at what level of increased volumes will this occur?

    Response: Yes. Refer to Section 4.4 of the ITB.

36. Will the contractor be able to export the 10% random sample (Institutional Admission Reviews) data from the AMMIS for use in mail merges?

    Response: No. The State has built a list of Provider's and addresses to utilize for mail merge. We can share this list with the Contractor.

37. Where do we find information relating to the long term care change process? (Page 11)

    Response: The Long Term Care Request for Action form is utilized by the Provider to request corrections to the long term care file. Refer to attachment P.

38. The performance guarantee, is it required when the ITB is submitted or at the time the contract is ratified?

Response: Performance guarantee is not required with the bid. It must be provided after notice of the award to the successful bidder.

39. Does the Hospice Room and Board request process include the 30 day reviews of hospice patients receiving room and board in a NH? (page 9)

    Response: There are no thirty day reviews of any hospice patients. The review is upon admission or financial award and subsequent six months for Medicaid only recipients. The dually eligible receiving room and board are not reviewed. The dates are submitted and research performed by a non-nursing person and entered into the LTC Admission software.

40. Will the contractor have export capabilities from the AMMIS for trending data?

    Response: The Contractor will have access to data within the AMMIS system for analysis such as lab, pharmacy etc.

41. Is there a requirement for the call center which supports this contract to be based in Alabama?

    Response: No.

42. Do providers have access to the criteria used by the reviewers?

    Response: The criteria for institutional admissions and hospice admissions are found in the Medicaid Administrative Code which is on the State web site. External criteria for prior approvals are published in the Medicaid Provider Manual.

43. Section 3.10 Please provide a detailed description of the new Medicaid system that is scheduled for implementation in May 2007.

    Response: The system is still in the development phase. Training for the system will be provided during implementation and with a projected date of May.

44. Please provide screen shots of the current system or “mock-ups” of the proposed system that indicate the prior authorization data.

    Response: Screen mock ups and a conversion mapping table are available upon request. Please contact Nancy Headley at (334) 242-5684 or e-mail at nancy.headley@medicaid.alabama.gov.

45. Will this system accept batch files of authorizations?

Response: Hospice and LTC Admissions are entered online through single transactions and then submitted into a nightly batch to EDS for processing. Authorizations for all other services must be submitted online through single transactions at this time. Any change to this process will have to be evaluated by Medicaid's fiscal agent, EDS.

46. Will Attachment F and G be web-based?

    Response: Attachment F Prior authorization request will continue to be routed to EDS for assignment of PA numbers and either scanned in or routed to the Contractor for review.
    Attachment G, hospice election and physician certification will not be web based. It will be received by fax for dually eligible or hard copy for desk review for the Medicaid only population.

47. Attachment D: Is there currently a backlog of requests awaiting prior authorizations, and has there been a history of backlog of requests? If there has been a history of request backlogs, how quickly were these requests processed?

    Response: There is not currently a backlog of requests for prior authorizations. Additional policies and procedures were implemented in December 2005. There has been no history of backlog since such implementation.

48. Attachment I: What percentage of prior authorization requests are received that does not contain complete documentation upon initial receipt by the state?

    Response: There are approximately 25% of prior authorizations which do not contain complete documentation.

49. Attachment O: Hospital –Inpatient services. Please clarify the type and volume of inpatient services.

    Response: Hospital admission reviews are not a component of this ITB. There are PA's for extended maternity care days and inpatient psychiatric days. Refer to attachment O for volumes of these services.

50. Medicare coverage doesn't mirror Medicaid coverage. Please clarify what is not covered by Medicaid in Alabama (specifically cosmetic services and procedures).

    Response: Please refer to Question 8.

51. Does Medicaid cover any dental services?

    Response: Please refer to question number 6.

52. Section 3.2 Hospice Admission Reviews: In reference to both the Hospice Room and Board Reviews, section 3.2, and the Long Term Care Change Requests for Dually Eligible recipients, section 3.3, the State has outlined that the volumes are 30 forms received a day. Can the State verify if the volume of 30 requests per day is for two different review types, or is the Hospice Room and Board review the same as the Long Term Care Change Request?

    Response: The volume is for two different processes, the hospice recipient status change request, attachment G, page 46 and Long Term Care Request for Action form, attachment P, page 59.

53. Section 3.2 Can the State provide historical data on the number of Hospice reviews referred to physician and number denied?

    Response: There have been approximately 50 records referred to the physician and approximately 90% have been denied since March 1, 2006.

54. What is the process when/if Institutional Provider does not submit retrospective review documentation within 10 days? Is that an automatic "technical" denial?

    Response: The State imposes a sanction which includes a penalty of one hundred dollars per day for each day of lateness. The Contractor must notify the provider of the date of imposition of the penalty.

55. What is the current process and method of requesting additional information for PEC/Swing bed reviews?

    Response: The Reviewer sends a letter notifying the Provider of the need for additional information. This program is relatively small. There are no more than 50 such requests annually.

56. What is the time frame the providers to submit additional information? Is that timeframe included within the 14 day required timeframe for review?

    Response: The provider must submit additional documentation within 10 working days. This timeframe is not included in the Contractor's 14 day requirement. The clock is reset upon receipt of the additional information.

57. Please clarify the term "VOA" provider.

    Response: VOA stands for Volunteers of America. There are two such providers which are ICF/MR providers.

58. Section 3.4 (page 12) Beginning July 1, 2007, Contractor shall review and process prior authorization requests, from physicians, DME providers, and other appropriate Medicaid providers identified in Medicaid program policy for

payment of medical procedures equipment and services requiring PA. Please clarify the review types/medical services under Prior Auth Review Requests.

Response: Please refer to Question 2.

59. Section 3.5: Does the state have expectations of quality screening to be done during reviews?

    Response: Refer to question 11.

60. Section 3.6: On page 14 of the ITB, 6th bullet, please clarify the expected number, location and duration of "presentations to groups/association or others" that would require the Contractor's attendance.

    Response: Refer to Question 18.

61. Section 3.10: Please clarify the rationale to justify the minimum system requirements, specifically for the Microsoft Windows version XP, CPU-3.0GHz, P4, 800FSB, Cache – IMB 1.2. Would the following system requirements be acceptable? CPU – 1.0 GHz, P3, 133FSB; Cache- 256Kb L2; Microsoft Windows 2000 Professional.

    Response: EDS indicates the requirements as listed (Microsoft Windows version XP, CPU-3.0GHz, P4, 800FSB, Cache-IMB 1.2) are necessary to ensure optimal performance.

62. Section 3.11 Key Personnel: Please clarify that the Project Manager does not need to be an FTE equivalent.

    Response: Refer to Question 20.